APT VIRGINIA

PATIENT INFORMATION FORM

Today's date:_____

Last Name: _____ First Name: _____Middle Initial: _____

Home Address: _____

City: _____ State: _____ Zip: _____Email Address: _____

Home Phone: (____) _____ Cellular Phone: (____) _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: F___ M___ Marital Status: _____

Employer Name & Address: _____

Work Phone: (____) _____ Ext: _____ Fax: (____) _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Primary Care Physician: _____ Referring Physician: _____

HEALTH INSURANCE INFORMATION

Will you be using your health insurance? __Yes __No I DO NOT HAVE HEALTH INSURANCE: _____ (initial)

Primary Insurance Carrier & Address: _____

Subscriber ID: _____ Group Number: _____ Phone number: _____

Policy Holder: _____ Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Carrier & Address: _____

Subscriber ID: _____ Group Number: _____ Phone number: _____

Policy Holder: _____ Date of Birth: _____ Relationship to Patient: _____

Is this related to an accident? If yes complete the following: __Yes __No

AUTOMOBILE ACCIDENT/ WORKERS COMPENSATION INSURANCE INFORMATION

Date of Accident: _____ Cause of Injury: __Auto __Work Comp __Other State Injury Occurred: _____

Insurance Carrier: _____ Med Pay Benefit Available: _____

Policy #: _____ Claim #: _____

Name of Adjuster: _____ Adjuster's Phone #: _____

Fax #: _____

Third Party Auto Insurance: _____ Policy #: _____ Phone #: _____

Attorney Name & Address: _____

Phone number: _____ Fax Number: _____ Case Manager: _____

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in Full (unless otherwise restricted by law or agreement we may have with your insurer). Also, some of the insurance companies only pay a percentage of the charge. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INDURANCE OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT. In the event the account is turned over for collections, the collections fees and/or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top

Patient's Signature: _____ Date: _____

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header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment via fax transmittal or hard copy.

Patient's Signature: _____ Date: _____